Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BROADWAY DENTAL

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-18-0437-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
OCTOBER 19, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted the Pre-Authorization for services to be rendered on several occasions and we received approval to proceed. Never were we informed that the services were approved at a lesser amount or we would have never agreed to perform the services. Now that the bridge is ready to be placed, the patient's account still has an outstanding balance from the difference in what was billed and what SORM paid."

Amount in Dispute: $1,546.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "services in dispute had been reimbursed in accordance with 28 Texas Administrative Code Chapter 134 Subsection 134.303 title Dental Fee Guideline. The Office determined that services billed under CPT D6750 were not preauthorized, however payment had been made pursuant to the Texas Medicaid Fee Schedule multiplied by 200%. Further research determined that charges as billed under CPT D6240 had received preauthorization and the Office maintains that payment had been made in accordance with the aforementioned rules."

Response Submitted by: SORM

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 9, 2016	D6750 (X2) Dental Services	$518.00/ea	$0.00
	D6240 Dental Services	$510.00	$0.00
TOTAL		$1,546.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.303, effective June 9, 2005, sets the reimbursement guidelines for the disputed services.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care would be fair and reasonable.
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197-Payment denied/reduced for absence of precertification/authorization.
   - 199-Number of services exceed utilization agreement.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 6060-Based on additional information from the claims examiner, we are recommending further payment be made for the above noted procedure code/codes.
   - RP3-CMS statutory exclusion/svc not paid to physicians.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the applicable fee guideline for dental services?
2. Does a preauthorization issue exist in this dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.303.
2. According to the submitted explanation of benefits, the respondent initially denied reimbursement for code D6240 based upon a lack of preauthorization. Upon reconsideration the respondent did not maintain the denial and issued payment of $528.00 for this code. The division finds that a preauthorization does not exist in this dispute.
3. The respondent paid $1,584.00 for the disputed services based upon the fee guideline and contends that additional reimbursement is not due. The requestor disagrees with the respondent's position and is seeking additional reimbursement of $1,546.00. To determine if additional reimbursement is due the division refers to 28 Texas Administrative Code §134.303.

   28 Texas Administrative Code §134.303(b) states "For coding, billing, reporting, and reimbursement of dental treatments and services, Texas Workers' Compensation system participants shall apply the Texas Medicaid Dental Fee Schedule in effect on the date a service is provided with any additions or exceptions in this section."

   On the disputed date the requestor billed codes D6240 and D6750 (X2).

   28 Texas Administrative Code §134.303(c) states "To determine the maximum allowable reimbursements (MARs), the following apply: (1) The fees listed for the procedure codes in the Texas Medicaid Dental Fee Schedule shall be multiplied by 200%."

   The division finds the following:

   - Code D6750 has a fee of $264.00 ; therefore, $264.00 X 200% = $528.00 X 2 = $1,056.00. The respondent paid $1,056.00. As a result additional reimbursement is not due.
   - Code D6240 has a fee of $264.00 ; therefore, $264.00 X 200% = $528.00. The respondent paid $528.00. As a result, additional reimbursement is not due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/14/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.